Health New England®

ONE MONARCH PLACE, SUITE 1500
SPRINGFIELD, MA 01144-1500
413-787-4000 or 800-842-4464
hne.com

STATE EMPLOYEES AND RETIREES ENROLLMENT/ADD FORM

GIC

Active employees, return this form to your GIC Coordinator.
Retirees, return the form to Health New England.

❑ NEW APPLICANT
(CHECK HERE ❑ IF YOU HAVE EVER BEEN IN HNE BEFORE)

CHANGES FOR CURRENT MEMBER
CHECK BELOW ALL THAT APPLY:

❑ CHANGE NAME ❑ ADD NEW DEPENDENT
❑ CHANGE ADDRESS/PHONE
❑ CHANGE CONTRACT TO FAMILY
❑ CHANGE MARITAL STATUS

SOCIAL SECURITY #

SUBSCRIBER NAME (LAST) (FIRST) (M.I.)

❑ CHECK HERE IF NEW NAME
WHAT WAS FORMER NAME?

MARITAL STATUS ❑ SINGLE ❑ MARRIED

HOME ADDRESS | CITY/TOWN | STATE | ZIP

HOME PHONE ( ) | WORK PHONE | SEX ❑ FEMALE ❑ MALE | DATE OF BIRTH MO. DAY YR. | TYPE OF CONTRACT ❑ SINGLE ❑ FAMILY

PRIMARY CARE PHYSICIAN (MUST BE FILLED IN TO GUARANTEE COVERAGE)

IS THIS YOUR PRESENT PHYSICIAN? ❑ YES ❑ NO

DEPENDENT INFORMATION - COMPLETE IF ENROLLING OR ADDING DEPENDENT(S).

LAST NAME IF DIFFERENT FROM SUBSCRIBER	FIRST NAME	M.I.	RELATION-SHIP	SEX M/F	DATE OF BIRTH MO DAY YR	PRIMARY CARE PHYSICIAN	PRESENT PHYSICIAN YES/NO
SPOUSE							
* DEPENDENT							
* DEPENDENT							
* DEPENDENT							
* DEPENDENT							
* DEPENDENT							

* DEPENDENT COVERAGE ENDS AUTOMATICALLY AT AGE 19. YOU MUST APPLY TO THE GROUP INSURANCE COMMISSION TO CONTINUE STUDENT OR HANDICAPPED DEPENDENT COVERAGE BEYOND AGE 19.

DOES ANYONE LISTED ABOVE HAVE MEDICARE? ❑ PART A ❑ PART B IF YES, PLEASE GIVE NAME(S):

HAS ANYONE LISTED ABOVE EVER BEEN A MEMBER OF HNE? ❑ NO ❑ YES IF YES, PLEASE GIVE NAME(S):

TYPE OF ENROLLMENT

A. ❑ NEW CONTRACT

REASON:
❑ NEWLY ELIGIBLE (N)

❑ ANNUAL ENROLLMENT PERIOD (O)

❑ MOVED INTO SERVICE AREA (M)

B. ❑ REINSTATED UNDER COBRA

C. ❑ CHANGE CONTRACT:
REASON:
MARRIED ON _____ (DATE)

CHILD BORN/ADOPTED ON _____ (DATE)

SPOUSE'S OTHER COVERAGE ENDED ON _____ (DATE)

OTHER _____

FOR PLAN USE

ARE YOU OR ANY FAMILY MEMBER COVERED BY OTHER MEDICAL INSURANCE? ❑ YES ❑ NO
IF YES, NAME OF INSURANCE COMPANY _____ POLICY NUMBER _____

I AUTHORIZE MY EMPLOYER TO DEDUCT PERIODICALLY FROM MY WAGES OR SALARY THE AMOUNT REQUIRED, IF ANY, FOR HEALTH NEW ENGLAND COVERAGE. I UNDERSTAND THAT MY HEALTH NEW ENGLAND MEMBERSHIP WILL BECOME EFFECTIVE WHEN ACCEPTED BY THE GROUP INSURANCE COMMISSION. I UNDERSTAND THAT IN ORDER TO BE COVERED, SERVICES MUST BE PROVIDED OR AUTHORIZED IN ADVANCE BY MY PRIMARY CARE PHYSICIAN OF RECORD, EXCEPT IN EMERGENCIES.

I HEREBY AUTHORIZE THE PLAN TO HAVE ACCESS TO ALL MEDICAL RECORDS AND HOSPITAL OR OTHER INSTITUTION OR AGENCY RECORDS RELATING TO DIAGNOSIS, TREATMENT OR SERVICES PROVIDED TO ME OR A COVERED DEPENDENT TO SUCH EXTENT AS MAY BE LAWFULLY PERMITTED.

I CERTIFY THAT ALL INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

EMPLOYEE SIGNATURE _____ **DATE** _____

SECTION D

EMPLOYER INFORMATION - MUST BE COMPLETED BY EMPLOYER

DEPT./WORKSITE (IF APPLICABLE) HNE GROUP #

DATE EMPLOYEE HIRED: **EFFECTIVE DATE OF COVERAGE/CHANGE**

CHANGE AUTHORIZED BY: _____ DATE _____
(REMITTER SIGNATURE)

4/04

(white) HEALTH NEW ENGLAND COPY (canary) GIC COPY (pink) EMPLOYEE COPY (gold) PAYROLL CLERK COPY